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PUBLICLY-FUNDED HEALTHCARE AND BIRTH DEFECTS IN TEXAS

The occurrence of birth defects poses many challenges to individuals, families and communities. Among these challenges is the financial cost of treating children with birth defects, much of which is borne in Texas by publicly-funded programs such as Medicaid, Medicaid Managed Care, and the state Children's Health Insurance Program (CHIP). In fact, at any given time about 2 million Texas children are enrolled in Medicaid (about one-third of all children in the state) and about 300,000 are covered by CHIP.

The tables below contain Medicaid and CHIP claims data for selected birth defects. In the upcoming year, Texas Birth Defects Epidemiology and Surveillance Branch staff hope to initiate further analyses of the economic cost of birth defects. As always, input from interested collaborators is welcome.

Texas Medicaid and CHIP Claims Related to Selected Birth Defects among Children Ages 0-18, State Fiscal Year 2005

Texas Fee-for-Service (FFS) and Primary Care Case Management (PCCM) Medicaid Claims

Birth Defect	Unduplicated Number of Children	Total Paid Amount	Average Cost Per Child
Cleft Lip & Palate	1,909	\$3,060,933	\$1,603
Down Syndrome	2,314	\$4,947,967	\$2,138
Microtia (small/absent ears)	302	\$512,625	\$1,697
Spina Bifida	1,435	\$5,348,540	\$3,727
Tetralogy of Fallot (heart defect)	659	\$7,427,972	\$11,272

Texas Managed Care (MCO) Medicaid Encounters

Birth Defect	Unduplicated Number of Children	Est. Paid Amount*	Estimated Average Cost Per Child
Cleft Lip & Palate	697	\$1,127,285	\$1,617
Down Syndrome	257	\$186,009	\$724
Microtia (small/absent ears)	87	\$166,375	\$1,912
Spina Bifida	203	\$276,952	\$1,364
Tetralogy of Fallot	146	\$2,007,806	\$13,752

Texas CHIP Encounters

Birth Defect	Unduplicated Number of Children	Est. Paid Amount*	Estimated Average Cost Per Child*
Cleft Lip & Palate	224	\$269,562	\$1,203
Down Syndrome	113	\$87,745	\$777
Microtia (small/absent ears)	48	\$180,929	\$3,769
Spina Bifida	116	\$125,168	\$1,079
Tetralogy of Fallot	68	\$188,926	\$2,778

Note: Texas Medicaid Managed Care and CHIP are paid on a capitation basis. Therefore, costs for these groups are not actual costs

Source: Research, Strategic Decision Support, Texas Health and Human Services Commission, December 2006.

FROM THE REGISTRY

RECURRENCE OF BIRTH DEFECTS IN A POPULATION BASED REGISTRY IN TEXAS 1995-2003

Contributed by Lisa Marengo Robinson, M.S., Texas Birth Defects Epidemiology & Surveillance Branch

Background

Birth defect recurrence examines the risk of a mother having another child with a birth defect, whether the same defect as the original one, or different. Recurrence studies within a family unit may elucidate whether the ongoing risk factor of defect recurrence has a genetic basis or environmental influences. However, due to the rare occurrence of many birth defects, there are few studies available on population based birth defect recurrence. The purpose of this project was to evaluate birth defect recurrence in a large, population-based Registry.

The Texas Birth Defects Epidemiology and Surveillance Branch began active surveillance birth defects data collection in pilot regions of the Lower Rio Grande Valley and the Greater Houston area in 1995. These pilot regions were expanded to encompass the entire state of Texas in 1999. Texas has one of the largest active surveillance population based birth defects registries in the world. Approximately 370,000 live births per year are currently monitored in Texas for birth defects, and on June 13, 2006 Texas ascertained its 100,000th birth defect case. With this large data set, it is now possible to examine questions about recurrence of birth defects.

Method

To identify mothers who appeared more than once in the Registry, we used linking to match records with identical maternal first and maiden name, residence, and date of birth. Remaining records were examined manually to look for other possible matches. Multiple gestation pregnancies were categorized by both the indication of twins, triplets,

etc., as well as identical dates of delivery and born to the same mother. An instance of sibling birth defect recurrence was defined as birth defect cases born on different dates but delivered to the same mother. For example, a set of twins born on 6/10/2001 without any other siblings being born to the same mother on a different date would not be counted as a case of recurrence, while a singleton sibling delivered in 1999 with a birth defect and a set of triplets delivered in 2001 to the same mother (one or more with a birth defect) would count as one instance of recurrence. All birth outcomes (such as live birth, fetal death, or elective termination) were included in the analysis.

Result and Discussion:

After excluding conjoined twins and multiple gestation pregnancies without an indication of recurrence of any birth defect in a separate pregnancy, 1,133 mothers delivered 2,299 children of various pluralities with birth defects: 2,228 singleton, 70 children who were from twin gestations, and 1 child who was the only triplet with a defect. In 22 mothers, there were three separate pregnancies with a birth defect. Twenty-two percent (247) of the 1,133 mothers were identified as having the same defect diagnosed in their subsequent children.

The table below lists 15 defects with relatively high rates of recurrence in the Texas Registry. The three most common recurrent defect diagnoses involved the cardiac and circulatory systems, listed in descending order: patent ductus arteriosus, atria septal defect and ventricular septal defect, which are also the most common birth defects in general among Texas deliveries.

Recurrent Cases of Selected Birth Defects, Texas Birth Defects Registry, Delivery Years 1995-2003		
Defect	# Recurrent Cases (Any defect in later siblings)	# Recurrent Cases (Same defect in later siblings)
Patent ductus arteriosus	386	123
Atrial septal defect	346	108
Ventricular septal defect	339	87
Hypospadias or epispadias	200	83
Pyloric stenosis	130	58
Obstructive genitourinary defect	129	21
Craniosynostosis	31	14
Pulmonary valve atresia or stenosis	61	12
Cleft lip with or without cleft palate	66	10
Cleft palate alone (without cleft lip)	44	6
Stenosis/atresia of large intestine, rectum, or anal canal	24	4
Reduction defects of the upper limbs	28	4
Reduction defects of the lower limbs	10	4
Trisomy 21 (Down syndrome)	53	4
Congenital hip dislocation	32	2

RESEARCH CENTER

WELCOME NEW STAFF

In 2006, we said goodbye to two staff members in the Texas Center for Birth Defects Research and Prevention, Beverly Taylor and Peter DeForest. We then welcomed Reggie Louis, Research Specialist, who will be taking over many of the administrative and logistical aspects of the Center, as well as contributing to research.

Mr. Louis earned a Bachelor of Science degree in Geography from the College of Geosciences in addition to a Master of Science degree from the Department of Health & Kinesiology at Texas A&M University in 2004 and 2006 respectively. He has previously served in the capacity of GIS analytical consultant with non-profit community health organizations and held a graduate research assistantship with the Texas A&M Center for the Study of Health Disparities. His current interests are behavioral aspects of birth defects prevention, paternal characteristics and adverse pregnancy outcomes, the geographic investigation of birth defects, and project management.

Reggie can be reached at 512-458-7232 Ext. 2004, reggie.louis@dshs.state.tx.us.

UPDATE FROM THE NATIONAL CENTERS FOR BIRTH DEFECTS RESEARCH AND PREVENTION ANNUAL MEETING

The Centers for Birth Defects Research and Prevention (CBDRP), which is comprised of the Centers for Disease Control and Prevention (CDC) National Center on Birth Defects and Developmental Disabilities (NCBDDD) and several state birth defects surveillance registries, recently held its annual meeting November 14-16, 2006 in Atlanta. Research scientist, project managers, clinicians, data managers, and several other representatives from federally funded centers across nine states, namely, Arkansas, California, Iowa, Massachusetts, North Carolina, New Jersey, New York, Texas, and Utah, attended the annual meeting.

The CBDRP assembled in Atlanta in order to assess the current status of the National Birth Defects Prevention Study (NBDPS). The NBDPS is an on-going, population-based case-control study designed to identify and understand preventable causes of common birth defects. Over the three-day period, many aspects of the national study were discussed and reviewed, particularly policy and procedures, project updates, and methodology. Several sessions consisted of scientific presentations in the form of oral and poster presentations. For instance, as lead investigator, Mark A. Canfield, Ph.D., manager of the Birth Defects Epidemiology and Surveillance Branch and co-principal investigator for the Texas Center for Birth Defects Research and Prevention of the

Texas Department of State Health Services, presented findings from: (1) Hispanic Ethnicity, Periconceptional Folic Acid Intake, and Neural Tube Defects and (2) Racial/Ethnic Patterns for Selected Birth Defects in the United States. Also presented were findings from a project entitled "Maternal Exposures to Cigarette Smoke, Alcohol, and Street Drugs and Neural Tube Defect Occurrence in Offspring," led by Lucina Suarez, Ph.D., Director of the Epidemiology and Surveillance Unit of the Texas Department of State Health Services. Closing remarks for the annual meeting were provided by Jennita Reefhuis, Ph.D., who is the new NBDPS principal investigator from the CDC.

While maintaining the highest level of confidentiality and ethical standards, it is expected that as more cases of birth defects are ascertained through the NBDPS, it will allow for the accumulation of enough information to enhance our ability to study birth defect etiology in increasingly meaningful ways.

RECENT PUBLICATIONS

Canfield MA, Honein MA, Yuskiv N, Xing J, Mai CT, Collins JS, Devine O, Petrini J, Ramadhani TA, Hobbs CA, Kirby RS. National estimates and race/ethnic-specific variation of selected birth defects in the United States, 1999-2001. *Birth Defects Res A Clin Mol Teratol*. 2006 Nov;76(11):747-56.

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PREVENTION

FOLIC ACID IN CEREAL BARS, ENERGY BARS, AND NUTRITIONAL DRINKS

Contributed by Krista Weaver, B.S. Community Health, Texas A&M University

Several public health authorities have issued recommendations or policies aimed at improving the folic acid intake among women of childbearing age. In 1992, the United States Public Health Service issued a recommendation that all women of childbearing age take in at least 0.4 milligrams (mg) of folic acid each day to reduce the chances of having a baby with a neural tube defect (NTD). In 1998, the National Academy of Sciences expanded on this, saying that the 0.4 mg of folic acid should come from fortified foods, vitamin supplements, or both, in addition to a varied diet. In January of that same year, the U.S. Food and Drug Administration (FDA) announced that all enriched grain products are required to be fortified at a level that would provide about 100 mcg additional folic acid to the diet of an average woman of childbearing age. While public information campaigns aimed at improving daily supplementation rates have met with limited success, folic acid fortification appears to have had a significant impact on NTD rates; both spina bifida and anencephaly rates have declined in the post-fortification period. Improved folic acid intake is also supported by the difference in blood folate levels between the National Health and Nutrition Survey (NHANES) III (1988-1994) and NHANES 1999, which increased in all women aged 15 – 44 (CDC, 2000 and 2004). However, exactly how and where women are getting their folic acid remains a mystery.

Preliminary research was done by the Texas Birth Defects Epidemiology and Surveillance Branch focusing on one potential source of folic acid: cereal bars, energy bars, and nutritional drinks. A huge market exists for these bars and drinks. According to a June 2003 publication of Consumer Reports, Americans have recently spent more than \$1.4 billion a year on such bars, making it the fastest-growing segment of the U.S. food industry (Consumer Reports 2003). The leader in this category, PowerBar, had sales of \$142 million in 1999 (Thompson 2000).

We visited several grocery stores in Austin, Texas and abstracted the nutritional information from selected bars/nutritional drinks containing at least 50% of the daily folic acid needs. See Table, right)

Clearly there are many options for obtaining a full day's folic acid, and many more options may become available as this market continues to grow. These (presumably) contain synthetic folic acid and are therefore considered 100% bioavailable, in contrast to food folate which naturally occurs in some foods.

This small study was conducted through several stores in the Central Texas area and there could be many other products available matching our search criteria in other regions of the

country. At this time it is difficult to quantify the amount of these products consumed by women of childbearing age (or other consumers). Developers of nutritional surveys such as National Health and Nutrition Examination Survey (NHANES) could improve access into this information by including these products in their surveys. Further study of this material may be warranted to better understand sources of folic acid and other micronutrients and their potential for preventing neural tube defects through fortified products.

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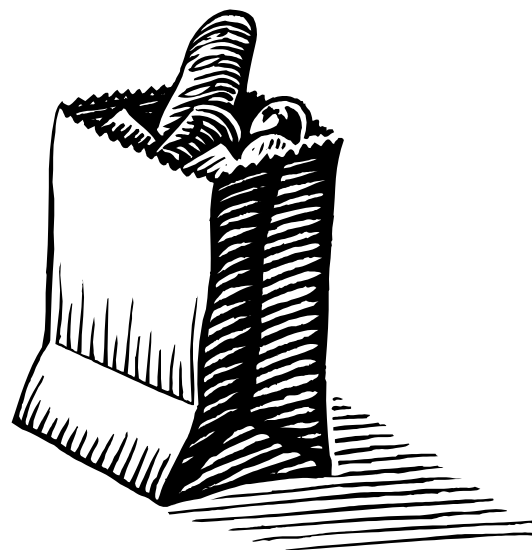
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- Consumer Reports. Energy bars, unwrapped. June 2003. Vol. 68, Issue 6, p 19-21.
- March of Dimes. Frequently Asked Questions About Folic Acid. November 2005. <http://www.marchofdimes.com/printableArticles/690_1403.asp>
- Thompson, Stephanie. Energy Bars Move up the Food Chain. Advertising Age. 2000. Vol. 71, Issue 5, p 26.

Table: Product and Percent of Daily Folic Acid per Serving

Cereal Bars	
General Mills Cinnamon Toast Crunch Milk and Cereal Bars	50%
General Mills Honey Nut Cheerio Milk and Cereal Bars	50%
Great Value Low Fat Fruit and Grain Bars-Apple Cinnamon	100%
Great Value Low Fat Fruit and Grain Bars-Blueberry	100%
Great Value Low Fat Fruit and Grain Bars-Mixed Berry	100%
Great Value Low Fat Fruit and Grain Bars-Strawberry	100%
Energy Bars	
Luna Bar – All flavors	100%
Genisoy Chocolate Fudge Brownie	100%
Genisoy Chocolate Mint Mocha Fudge	100%
Genisoy Fudge Cookies and Cream	100%
Genisoy Peanut Butter Fudge	100%
Muscle Tech Meso Tech Complete – Cookies and Cream	100%
Muscle Tech Meso Tech Complete – Peanut Butter Chocolate	50%
Nutrabella All Natural Bellybar – Baby Needs Chocolate	200%
Nutrabella All Natural Bellybar – Crunchy Nuts and Berries	210%

Energy Bars, Continued	
Powerbar Harvest Energy Bar – Chocolate	50%
Powerbar Harvest Energy Bar – Yogurt Dipped	50%
Powerbar High Performance Energy Bar-Chocolate PB	100%
Powerbar Nutritional Energy Snack Bar-Chocolate Cookie	60%
Powerbar Performance Energy Bar-Chocolate	100%
Powerbar Performance Energy Bar-Peanut Butter	100%
Powerbar Performance Energy Bar-Vanilla Crisp	100%
Powerbar Protein Plus High Protein Bar-Chocolate	100%
Powerbar Protein Plus High Protein Bar-Peanut Butter	100%
Powerbar Triple Threat Energy Bar-Chocolate PB	50%
Powerbar Triple Threat Energy Bar-Toffee Chocolate Chip	50%
Powerbar-Apple Cinnamon	100%
Pria Nutrition Bar-Chocolate Peanut Butter Crisp	60%
Pria Nutrition Bar-Chocolate Peanut Crunch	60%
Pria Nutrition Bar-French Vanilla Crisp	60%
Snickers Marathon Low Carb Energy Bar-Chocolate Fudge	100%
Snickers Marathon Protein Energy Bar-Caramel Nut Rush	100%
Snickers Marathon Protein Energy Bar-Chocolate Nut Burst	100%
Vincent Foods Oh Mama Bar-Chocolate PB	100%
Vincent Foods Oh Mama Bar-Frosted White Raspberry	100%
Vincent Foods Oh Mama Bar-Lemon Zest	100%
Diet Drinks	
Alacer Emer'gen C-Instant Strawberry	50%
Carb Solutions High Protein Shake for Low Carb Diets-Creamy Vanilla	100%
Carb Solutions High Protein Shake for Low Carb Diets-Rich Chocolate	100%
Diet Lean Low Carb Dieter's Shake-Chocolate	50%
Diet Lean Low Carb Dieter's Shake-Vanilla	50%
EAS Myoplex Integrated Formula Nutrition Shake-Chocolate Cream	50%
EAS Myoplex Integrated Formula Nutrition Shake-Strawberry Cream	50%
EAS Myoplex Integrated Formula Nutrition Shake-Vanilla Cream	50%
EAS Myoplex Deluxe Nutrition Shake with Sucralose-Chocolate Cream	50%
EAS Myoplex Deluxe Nutrition Shake with Sucralose-Strawberry Cream	50%
EAS Myoplex Deluxe Nutrition Shake with Sucralose-Vanilla Cream	50%
EAS Myoplex Lite Ready to Drink-Cappuccino	100%
EAS Myoplex Lite Ready to Drink-Chocolate Fudge	90%

Diet Drinks, Continued	
EAS Myoplex Lite Ready to Drink-French Vanilla	90%
EAS Myoplex Original Nutrition Shake with Sucralose-Chocolate Cream	50%
EAS Myoplex Original Nutrition Shake with Sucralose-Chocolate Lovers	50%
EAS Myoplex Original Nutrition Shake with Sucralose-Strawberry Cream	50%
EAS Myoplex Original Nutrition Shake with Sucralose-Tropical Lovers	50%
EAS Myoplex Original Nutrition Shake with Sucralose-Vanilla Cream	50%
EAS Myoplex Original Nutrition Shake-Strawberry Cream	50%
Glucerna Shake for People with Diabetes-Butter Pecan	50%
Glucerna Shake for People with Diabetes-Chocolate	50%
Glucerna Shake for People with Diabetes-Strawberry	50%
Glucerna Shake for People with Diabetes-Vanilla	50%
Glucerna Weight Loss Shake-Chocolate	50%
Glucerna Weight Loss Shake-Vanilla	50%
GNC Pro Performance Creatine Burst-Fruit Punch	50%
Hollywood Miracle Diet Hollywood 48 Hour Miracle Diet	75%
Natures Plus Spiru-Tein High Protein Energy Meal-Chocolate	100%
Natures Plus Spiru-Tein High Protein Energy Meal-Vanilla	100%
Prolab Naturally Lean Complex Meal Supplement-Cinnamon Oatmeal	100%
Zone Perfect All Natural Nutrition Shake-Chocolate Royale	50%
Zone Perfect All Natural Nutrition Shake-Creamy Vanilla	50%



CURRENT FOLIC ACID RECOMMENDATIONS FOR DIABETIC WOMEN OF CHILDBEARING AGE: IMPLICATIONS FOR PROFESSIONAL CONTINUING EDUCATION

Contributed by Bobbiejean Garcia, M.P.H., University of Texas School of Public Health

Obese and diabetic women are at higher risk of having a pregnancy affected by neural tube defects (NTDs). It has also been shown that women who consume 400µg of folic acid, despite their chronic disease status, can reduce this risk by 50-72%. In the summer of 2006, an intern working with the Texas Birth Defects Epidemiology and Surveillance Branch researched current professional guidelines, standard practices, and other recommendations regarding folic acid supplementation for obese or diabetic women of childbearing age (WCBA). The following is a report of these findings and recommendations on developing a continuing education module regarding diabetes and folic acid for several professions in the state of Texas for birth defect prevention.

Scientific literature regarding professional recommendations for folic acid supplementation in obese and diabetic women was searched. In addition to this, literature regarding obesity, diabetes, neural tube defects and the effects of folic acid on the offspring was searched. From this initial search, a limited number of articles were returned on studies of obese women, neural tube defects and folic acid. The articles dealing with obese women were ultimately eliminated from the search. Through this research, professions that routinely encounter diabetic WCBA were examined.

Professions that dealt with this population on a regular basis were selected. These professions are included in a broad category: nurses, physicians, dietitians, and community health workers (or *promotoras*). The largest education provider or professional organization representing each of these professions was selected and invited to participate in a phone survey to assess their practices regarding counseling diabetic women on their need for folic acid. Professional organizations were contacted via phone and education providers were contacted through email. A copy of the phone script and email sent are included. While several organizations expressed interest, only one stated willingness to modify any current curricula to include specific folic acid recommendations for diabetic women.

Regarding professional recommendations for folic acid supplementation for diabetic WCBA we found:

- There is limited research on the effects of folic acid supplementation specifically on the diabetic population.
- There currently exists no consensus on folic acid supplementation specifically for diabetic women of child bearing age, aside from the standard 400µg for all WCBA.

- The March of Dimes does recommend that diabetic women “should ask their providers before pregnancy about whether they should take a larger dose of folic acid”.
- Survey respondents were uncertain whether a continuing education module should be specifically developed for this reason, although they agreed it is important that WCBA, especially diabetic women, understand the importance of consuming folic acid.

Recommendations from this research:

An educational module should discuss particular needs of diabetic women including their heightened risk of having an NTD-affected pregnancy and the strong importance of recommending the current folic acid supplementation to this population.

Continued research should investigate whether diabetic women need to consume additional folic acid on top of the current recommended 400µg to further reduce their risk.

Continued research should investigate whether diabetic women who control their blood glucose prior to and during early pregnancy and consume the recommended 400µg of folic acid have similar rates of birth defects or NTDs when compared to non-diabetic women who consume the recommended 400µg of folic acid.

Ultimately, it is recommended that professionals who deal with diabetic WCBA on a regular basis receive continuing education that discusses neural tube defects and the importance of folic acid, where the topics are discussed with regard to both the non-diabetic and diabetic population.

CONSUMPTION ADVISORY ISSUED FOR TWO SPECIES OF CANYON LAKE FISH

The Texas Department of State Health Services (DSHS) has issued an advisory warning people to limit their consumption of striped bass and longnose gar from Canyon Lake, which is in Comal County about 12 miles northwest of New Braunfels. The advisory was issued after laboratory testing detected elevated levels of mercury in the two species. Mercury is a naturally occurring element that gets into air and water from the weathering of the earth's crust, from the burning of fossil fuels and from some industrial discharges and emissions.

Regular ingestion of methyl mercury, the mercury compound in the fish, can harm the human



(Continued on page 7)

brain and nervous system, and can permanently damage those systems in a fetus if the mother-to-be eats foods containing elevated levels of mercury during pregnancy. Pregnant women, women who could become pregnant and mothers who are breastfeeding are advised not to eat any striped bass or longnose gar from the lake.

Young children are also at special risk. Adults and children 12 and older are advised to eat no more than two 8-ounce servings per month, and children under 12 should eat no more than two 4-ounce servings per month.

Test results for largemouth bass, white bass, blue catfish and flathead catfish from Canyon Lake did not show elevated levels of mercury. Those species are not included in the consumption advisory. There is no risk of mercury poisoning from fishing, skiing or swimming in Canyon Lake.

LIVING WITH BIRTH DEFECTS

WORKERS WITH DISABILITIES CAN NOW BUY MEDICAID BENEFITS

Texas workers with disabilities now can apply for extended health insurance benefits even if their income exceeds traditional Medicaid limits.

Medicaid provides health-care services for about 300,000 low-income Texans who have disabilities. The traditional program provides coverage for a Texan with a disability earning up to \$604 per month, or \$7,252 a year, for a single person. The new Medicaid Buy-In program began September 1, 2006.

“Under the traditional program, a worker who has a disability sometimes had to choose between a higher-paying job without insurance or staying in a lower-paying job to keep their Medicaid coverage,” said Texas Health and Human Services Executive Commissioner Albert Hawkins. “This new program eliminates that difficult decision and allows workers to earn more without the fear of losing their health-care coverage.”

The Medicaid Buy-In Program, authorized by the Texas Legislature in 2005, allows workers who have a disability to receive Medicaid by paying a monthly premium. The premium is based on the person’s income and other factors.

“This program essentially allows workers who have disabilities to leverage the buying power of the state’s \$18-billion-a-year Medicaid program,” Hawkins said. “It’s an innovative program that expands coverage in a cost-effective way.”

People in the Medicaid Buy-In program will have access to the same Medicaid services available to adult Medicaid recipients, which include office visits, hospital stays, X-rays, vision services, hearing services and prescriptions.

Workers with disabilities who want to find out whether they qualify for the Medicaid Buy-In program can call 2-1-1 for more information or to locate an office where they can apply. For more information, visit www.hhsc.state.tx.us/medicaid/buy_in_QNA.html.

ANNOUNCEMENTS

DSHS BEGINS EXPANDED SCREENING OF NEWBORNS

The Texas Department of State Health Services (DSHS) is now testing “heel stick” blood samples from newborns for 26 disorders, with a 27th to be added early next year. Previously, newborns were screened for seven conditions.

“We are pleased to announce that the Newborn Screening Program expansion has begun and is now giving important clinical information to health care providers and families,” said Dr. Charles Bell, DSHS Acting Commissioner. “Early detection of these disorders allows early treatment that can prevent serious complications such as growth problems, developmental delays, deafness or blindness, mental retardation, seizures or early death.”

All babies born in Texas are required to have two rounds of screening tests for certain inheritable and other disorders. The Newborn Screening Program identifies those infants who have an abnormal screen at birth or shortly afterward. An abnormal laboratory result triggers follow-up and case management to contact the health care provider to take appropriate action.

House Bill 790, passed by the Texas Legislature in 2005, mandated that DSHS screen for additional disorders recommended by the American College of Medical Genetics as funding allows. DSHS receives about 760,000 newborn specimens annually.

Babies continue to receive hearing screenings as well.

Information about the DSHS Newborn Screening Program and the disorders covered are available online at www.dshs.state.tx.us/newborn/default.shtm.

Did you know . . . ?

Pediatric hospital stays in the U.S. for treating birth defects average 7.4 days and cost nearly \$50,000 each stay.

Source: <http://hcup.ahrq.gov/HCUFnet.jsp>



The *Monitor* is published twice a year by the Birth Defects Epidemiology and Surveillance Branch, Texas Department of State Health Services:

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CALENDAR

February

4-7 National Birth Defects Prevention Network Annual Meeting, San Antonio. Contact: Cara Mai, 404-498-3918, www.nbdpn.org.

25-27: Texas Public Health Association 82nd Annual Education Conference, Galveston. www.charityadvantage.com/texaspha/Home.asp Contact: 512-336-2520, txpha@aol.com

March

3: Power of Healthy Women (Seminar, Health Fair) Saturday, 9 a.m.- 2:39 p.m., Texas Woman's University, Denton. Contact: 940-898-2792

April

12-14: Texas Genetics Society Annual Meeting, San Antonio. Contact: 813-615-4377, Sue.Berend@genzyme.org. www.texasgeneticsociety.org/

May

19-23: 23rd Annual TEPR - Towards the Electronic Patient Record -- Conference & Exhibition will take place May 19-23, 2007 Dallas Convention Center. <http://www.medrecinst.com/conference/tepr/index.asp> Contact: 617-964-3923 email: info@medrecinst.com.

June

27-29: Texas Health Information Management Association Annual Convention, San Antonio. www.txhima.org/events_annualmeeting.htm Contact: 512.392.4715 txhima@txhima.org.

October

13: Houston Child Life Conference 2007, Texas Children's Hospital, Houston. www.texaschildrenshospital.org/CareCenters/ChildLife/Default.aspx Contact: 832-826-1650 ChildLife@texaschildrenshospital.org